

KanCare SMI Health Homes Provider Requirements

Health Home Entities	Requirements
Lead Entity (LE)	<p><u>The Lead Entity must:</u></p> <ol style="list-style-type: none"> 1. Maintain a valid certificate of authority as a Health Maintenance Organization from the Kansas Insurance Department 2. Have NCQA accreditation for its Medicaid managed care plan 3. Must have authority to access Kansas Medicaid claims data for the population served. 4. Must have a statewide network of providers to service member with SMI. 5. Must have the capacity to evaluate, select and support providers who meet the standards for HHPs, including: <ul style="list-style-type: none"> • Identification of providers who meet the HHP standards • Provision of infrastructure and tools to support HHPs in care coordination • Gathering and sharing member-level information regarding health care utilization, gaps in care and medications • Providing outcome tools and measurement protocols to assess HHP effectiveness • Developing and offering learning activities that will support HHPs in effective delivery of HH services
Health Home Partner (HHP)	<p><u>The HHP must:</u></p> <ol style="list-style-type: none"> 1. Meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following: <ul style="list-style-type: none"> • Center for Independent Living • Community Developmental Disability Organization • Community Mental Health Center • Community Service Provider – for people with intellectual / developmental disabilities (I/DD) • Federally Qualified Health Center/Primary Care Safety Net Clinic • Home Health Agency • Hospital – based Physician Group • Local Health Department • Physician – based Clinic • Physician or Physician Practice • Rural Health Clinics • Substance Use Disorder Provider 2. Enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements 3. Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls 4. Provide appropriate and timely in-person care coordination activities. Alternative communication methods in addition to in-person such as telemedicine or telephonic contacts may also be utilized if culturally appropriate and accessible for the enrollee to enhance access to services for members and families where geographic or other barriers exist 5. Have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals 6. Agree to accept any eligible enrollees, except for reasons published in the

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	<p>Kansas Health Homes Program Manual</p> <ol style="list-style-type: none"> 7. Demonstrate engagement and cooperation of area hospitals, primary care practices and behavioral health providers to collaborate with the HHP on care coordination and hospital / ER notification 8. Commit to the use of an interoperable EHR through the following: <ol style="list-style-type: none"> a. Submission of a plan, within 90 days of contracting as a HHP, to implement the EHR b. Full implementation of the EHR within 12 months of contracting as a HHP (timeline approved by the Lead Entity) c. Connection to one of the certified state HIE, KHIN or LACIE, within 18 months of contracting to be a HHP (timeline approved by the Lead Entity)
Joint Requirements (LE and HHP)	<p><u>The Lead Entity and the Health Home Partner jointly must:</u></p> <ol style="list-style-type: none"> 1. Provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees 2. Ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay 3. Ensure person and family-centered and integrated health action planning that coordinates and integrates all his or her clinical and non-clinical health care related needs and services 4. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy 5. Establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers 6. Demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner: <ol style="list-style-type: none"> a. Coordinate and provide the six core services outlined in Section 2703 of the Affordable Care Act b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders d. Coordinate and provide access to mental health and substance abuse services e. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families f. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate g. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical

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	<p>outcomes, experience of care outcomes, and quality of care outcomes at the population level</p> <p>7. Demonstrate the ability to report required data for both state and federal monitoring of the program</p>